United States Department of Labor
Employees' Compensation Appeals Board

A.C., Appellant	)	
and	)	**Docket No. 18-1730**
	)	**Issued: July 23, 2019**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Decatur, GA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, JUDGE

JURISDICTION

On September 16, 2018 appellant filed a timely appeal from a May 18, 2018 merit decision and August 28, 2018 nonmerit decision[1] of the Office of Workers' Compensation Programs

[1] Appellant submitted additional evidence following the May 18, 2018 decision. However, "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id.*

(OWCP).[2] Pursuant to the Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[4]

ISSUES

The issues are: (1) whether appellant has met her burden of proof to establish more than two percent permanent impairment of her right lower extremity and more than 13 percent permanent impairment of her right upper extremity, for which she previously received schedule award compensation; and (2) whether OWCP properly denied appellant's request for reconsideration as it was untimely filed and failed to demonstrate clear evidence of error.

FACTUAL HISTORY

On June 6, 2013 appellant, then a 43-year-old practical nurse, filed a traumatic injury claim (Form CA-1) alleging that on June 5, 2013 she sustained injury to her right arm/shoulder when she fell and hit her right side on the floor while in the performance of duty. She stopped work for intermittent periods after June 5, 2013. OWCP initially accepted appellant's claim for enthesopathy of her right hip, disorder of the bursae/tendons of her right shoulder, and thoracic or lumbosacral neuritis/radiculitis. It paid her wage-loss compensation on the daily rolls commencing August 6, 2013.

Medical records from appellant's initial visit to the employing establishment's health unit on June 6, 2013, and her follow-up visits during the subsequent several months, show that she primarily complained of pain in her right shoulder, forearm, hip, and knee, as well as in her low back. On June 14, 2013 Dr. Chandra Armstrong, a Board-certified family practitioner, advised that the findings of June 6, 2013 x-ray testing of appellant's right knee were normal. She diagnosed a right knee contusion. In a January 31, 2014 report, Dr. Christopher Haraszti, a Board-certified orthopedic surgeon, noted appellant's complaints of cervical, right shoulder, right wrist, and lumbar pain, but he opined that her medical condition was not related to the June 5, 2013 fall. He released appellant to full duty. Appellant later received care for her multiple medical problems from Dr. Thomas Branch, a Board-certified orthopedic surgeon, who indicated that she did not complain of cervical or right knee symptoms during a January 27, 2016 physical examination.

On September 12, 2016 appellant requested that OWCP expand the accepted conditions in her case. She asserted that she sustained cervical and right knee conditions as a direct result of the

[2] By decision dated April 26, 2019, OWCP denied appellant's claim for a schedule award. The Board and OWCP may not exercise simultaneous jurisdiction over the same issue(s) in a case on appeal. 20 C.F.R. § 501.2(c)(3). Following the docketing of an appeal before the Board, OWCP does not retain jurisdiction to render a further decision regarding the issue(s) on appeal until after the Board relinquishes jurisdiction. *Id.* Thus, the April 26, 2019 OWCP decision is null and void. *See id.; Terry L. Smith*, 51 ECAB 182 (1999); *Arlonia B. Taylor*, 44 ECAB 591 (1993); *Douglas E. Billings*, 41 ECAB 880 (1990).

[3] 5 U.S.C. § 8101 *et seq.*

[4] Together with her appeal request, appellant submitted a timely request for oral argument pursuant to 20 C.F.R. § 501.5(b). After exercising its discretion, by order dated March 6, 2019, the Board denied the request as appellant's arguments on appeal could be adequately addressed in a decision based on a review of the case as submitted on the record. *Order Denying Request for Oral Argument*, Docket No. 18-1730 (issued March 6, 2019).

June 5, 2013 employment incident. By decision dated September 22, 2016, OWCP expanded appellant's accepted conditions to include lumbosacral radiculopathy and bicipital tendinitis of her right shoulder.

On November 1, 2016 appellant had filed a claim for a schedule award (Form CA-7) due to her accepted employment conditions.

By decision dated November 18, 2016, OWCP denied appellant's request for expansion of her accepted conditions to include consequential cervical and right knee conditions, noting that she had not submitted medical evidence sufficient to establish causal relationship between her accepted June 5, 2013 injury and the claimed consequential cervical and right knee problems.

On December 7, 2016 appellant, through her then counsel, requested a telephonic hearing with a representative of OWCP's Branch of Hearings and Review. Appellant subsequently submitted March 7, April 18, and May 22, 2017 reports from Dr. Branch who diagnosed cervical disc disorder with radiculopathy and opined that this condition was related to appellant's June 5, 2013 fall. During the hearing held on June 15, 2017, she testified that she hit her right knee on the floor when she fell on June 5, 2013 and that her neck jerked backwards and forwards.

By decision dated August 3, 2017, OWCP's hearing representative affirmed OWCP's November 18, 2016 decision denying appellant's request for expansion of her accepted conditions.

In support of her schedule award claim, appellant submitted a February 23, 2017 report from Dr. Richard M. Blecha, an attending Board-certified orthopedic surgeon, who advised that appellant presented complaining of pain in her right shoulder, the lateral aspect of her right thigh, low back, and neck (with tingling/numbness radiating in her right hand). Dr. Blecha summarized appellant's factual and medical history and detailed the findings of his February 23, 2017 physical examination, noting that right leg raise testing elicited a complaint of right lateral hip/thigh pain at 60 degrees of flexion. Appellant had 5/5 muscle strength in her upper and lower extremities, although she reported pain upon muscle testing of her right lower extremity. With respect to range of motion (ROM) testing of the right shoulder, Dr. Blecha indicated that appellant had 100 degrees of flexion, 20 degrees of extension, 100 degrees of abduction, 30 degrees of adduction, 50 degrees of internal rotation, and 20 degrees of external rotation.

Dr. Blecha provided an impairment rating of appellant's right lower extremity using the diagnosis-based impairment (DBI) rating method under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5] He found that, under that Table 16-4 (Hip Regional Grid) beginning on page 512, appellant's primary diagnosis of right hip trochanteric bursitis (class 1) warranted a default value of two percent. Dr. Blecha determined that appellant had a grade modifier for functional history (GMFH) of 0 (no limp), grade modifier for physical examination (GMPE) of 2 (moderate palpatory findings), and grade modifier for clinical studies (GMCS) of 0 (no relevant studies available). Application of the net adjustment formula did not result in a change from the two percent default value for permanent impairment of the right lower extremity.

[5] A.M.A., *Guides* (6th ed. 2009).

With respect to appellant's right upper extremity, Dr. Blecha applied the DBI rating method under Table 15-5 (Shoulder Regional Grid) beginning on page 401 and found that her primary diagnosis of right shoulder tendinitis/bursitis (class 1) warranted a default value of three percent for permanent impairment of the right upper extremity. He determined that appellant had a GMFH of 2 (pain with normal activity), GMPE of 1 (minimal palpatory findings), and GMCS of 0 (normal diagnostic testing of lumbar spine). Application of the net adjustment formula did not result in a change from the three percent default value for permanent impairment of the right upper extremity.

On March 5, 2017 OWCP referred appellant's case to Dr. Arthur S. Harris, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA). It requested that Dr. Harris provide a rating of permanent impairment for appellant's right lower and right upper extremities under the standards of the sixth edition of the A.M.A., *Guides.*

In a March 31, 2018 report, Dr. Harris advised that he had reviewed the medical evidence of record, including Dr. Blecha's February 23, 2017 report. He explained that, where the A.M.A., *Guides* allows for use of both the DBI and ROM rating methods, the rating method producing the higher rating should be used. With respect to the right lower extremity, Dr. Harris applied the DBI rating method and found that, under Table 16-4 of the sixth edition of the A.M.A., *Guides*, appellant had a primary diagnosis of right hip strain (class 1) which warranted a finding of two percent permanent impairment of the right lower extremity. He advised that the A.M.A., *Guides* did not allow for the use of the ROM impairment rating method for the diagnosis of hip strain and concluded that appellant's right lower extremity permanent impairment totaled two percent.

With respect to appellant's right upper extremity impairment, Dr. Harris initially applied the DBI rating method and found that, under Table 15-5, appellant had a primary diagnosis of right rotator cuff tendinitis (class 1) which warranted a finding of three percent permanent impairment of the right upper extremity. However, he further explained that, for this diagnosis, the A.M.A., *Guides* allowed for use of the ROM rating method. Under Table 15-34 on page 475, appellant had 13 percent permanent impairment of her right upper extremity due to addition of the following ROM deficits for the right shoulder: three percent due to 100 degrees of flexion; two percent due to 20 degrees of extension; three percent due to 100 degrees of abduction; one percent due to 30 degrees of adduction; two percent due to 50 degrees of internal rotation; and two percent due to 20 degrees of external rotation. Dr. Harris determined that the combined permanent impairment rating of appellant's right upper extremity was 13 percent because the ROM rating method yielded a higher impairment than the DBI rating method.[6]

By decision dated May 18, 2018, OWCP granted appellant a schedule award for 2 percent permanent impairment of her right lower extremity and 13 percent permanent impairment of her right upper extremity. The award ran for 46.32 weeks from April 24, 2018 to March 14, 2019 and was based on the impairment rating of the DMA.

On August 8, 2018 appellant requested reconsideration of OWCP's August 3, 2017 decision denying her request for expansion of the accepted conditions to include cervical and right

[6] Dr. Harris advised that appellant reached maximum medical improvement on February 23, 2017, the date of the examination by Dr. Blecha.

knee conditions. She again argued that she sustained injury to her neck and right knee as a direct result of her June 5, 2013 fall.

In support of her request for reconsideration, appellant submitted a June 25, 2018 letter from Dr. Rudolph V. Tacoronti, a Board-certified occupational medicine physician, who served as a health officer for the employing establishment. Dr. Tacoronti advised that an unspecified attending physician had diagnosed a right knee sprain/strain in mid-2013. In a May 22, 2017 note, Dr. Branch recommended physical therapy for appellant's right shoulder condition. Appellant submitted a hospital discharge record from August 2017, prescription refill orders from 2017 and 2018, and lumbar spine diagnostic testing results from June 2018.

Appellant also submitted November 6, 2017 and June 12, 2018 documents which included examination findings. The documents list Dr. Branch as a "provider," but they do not contain a signature block and have not been signed by Dr. Branch or any other person.

By decision dated August 28, 2018, OWCP denied appellant's request for reconsideration, finding that it was untimely filed and failed to demonstrate clear evidence of error in its August 3, 2017 decision which denied her request for expansion of the accepted conditions.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provision of FECA[7] and its implementing federal regulation[8] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[9] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[10]

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated.[11] The sixth edition requires identifying the impairment class for the class of diagnosis

[7] 5 U.S.C. § 8107.

[8] 20 C.F.R. § 10.404.

[9] *Id*. at § 10.404(a).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (March 2017); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[11] With respect to the shoulder, the relevant portion of the arm for the present case, reference is made to Table 15-5 (Shoulder Regional Grid). With respect to the hip, the relevant portion of the leg, reference is made to Table 16-4 (Hip Regional Grid). A.M.A., *Guides* (6th ed. 2009) 401-05, 512-15, Table 15-5, Table 16-4. Table 15-5 also provides that, if motion loss is present for a claimant with certain diagnosed conditions, impairment may alternatively be assessed using section 15.7. Such a ROM impairment stands alone and is not combined with a DBI. *Id.* at 401-05, 475-78.

(CDX), which is then adjusted by grade modifiers including GMFH, GMPE, and GMCS.[12] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[13]

With respect to the standards for conducting ROM evaluations, section 15.7 of the sixth edition of the A.M.A., *Guides* provides:

> "[ROM] should be measured after a "warm up," in which the individual moves the joint through its maximum [ROM] at least [three] times. The [ROM] examination is then performed by recording the active measurements from [three] separate [ROM] efforts. Measurements should be rounded up or down to the nearest number ending in 0…. All measurements should fall within 10 [degrees] of the mean of these three measurements. The maximum observed measurement is used to determine the [ROM] impairment."[14]

Regarding the application of ROM or DBI impairment methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

> "As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (via the updated instructions noted above) to the rating physician(s)."
>
> "Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify (1) the methodology used by the rating physician (*i.e*. DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*" (Emphasis in the original.)[15]
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> The Bulletin further advises:
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> "If the rating physician provided an assessment using the DBI method and the [A.M.A.,] *Guides* allow for use of ROM for the diagnosis in question, the DMA should independently calculate impairment using both the ROM and DBI methods and identify the higher rating for the CE.
>
> "If the medical evidence of record is not sufficient for the DMA to render a rating on ROM where allowed, the DMA should advise as to the medical evidence

[12] *See* A.M.A., *Guides* 405-11.

[13] *Id.* at 411-12.

[14] *Id.* at 464.

[15] FECA Bulletin No. 17-06 (issued May 8, 2017).

necessary to complete the rating. However, the DMA should still render an impairment rating using the DBI method, if possible, given the available evidence."[16]

The sixth edition of the A.M.A., *Guides* provides a DBI method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[17] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment of the class of diagnosis (CDX) condition, which is then adjusted by grade modifiers of GMFH, GMPE, and GMCS.[18] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[19]

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish more than two percent permanent impairment of her right lower extremity, for which she previously received a schedule award. The Board further finds that the case is not in posture for decision with respect to the extent of appellant's right upper extremity permanent impairment.

With respect to permanent impairment of the right lower extremity, OWCP properly based its May 18, 2018 schedule award on the March 31, 2018 calculation of the DMA who applied the appropriate standards of the sixth edition of the A.M.A., *Guides* to the February 23, 2017 examination findings of Dr. Blecha. He provided an impairment rating in accordance with that provided by Dr. Blecha and correctly concluded that appellant had two percent permanent impairment of her right lower extremity. The DMA applied the DBI rating method and found that, under Table 16-4 of the sixth edition of the A.M.A., *Guides*, appellant had a primary diagnosis of right hip strain (Class 1) which warranted a finding of two percent permanent impairment of the right lower extremity.[20] He properly advised that the A.M.A., *Guides* did not allow for the use of the ROM impairment rating method for appellant's diagnosed right hip condition.[21]

With respect to the right upper extremity, the DMA should identify the methodology used by the rating physician (DBI or ROM) and whether the applicable tables in Chapter 15 of the A.M.A., *Guides* identify a diagnosis that can alternatively be rated by ROM. If the A.M.A., *Guides* allow for the use of both the DBI and ROM methods to calculate an impairment rating for the

[16] *Id*.

[17] A.M.A., *Guides*, *supra* note 7 at page 3, section 1.3, The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement.

[18] *Supra* note 14.

[19] *Supra* note 15.

[20] Dr. Blecha had determined that appellant had a GMFH of 0, GMPE of 2, and GMCS of 0, and he had opined that application of the net adjustment formula did not result in a change from the two percent default value for permanent impairment of the right lower extremity. The DMA also found that there was no need to change from this two percent default value. *See supra* notes 12 and 13.

[21] A.M.A., *Guides* 512, Table 16-4.

diagnosis in question, the method producing the higher rating should be used.[22] Moreover, with respect to the standards for conducting ROM evaluations, section 15.7 of the sixth edition of the A.M.A., *Guides* provides that, after warm-up motions, the ROM examination is performed by recording the active measurements from three separate ROM efforts. All measurements should fall within 10 degrees of the mean of these three measurements and the maximum observed measurement is used to determine the ROM impairment.[23]

Table 15-5 provides that, if motion loss is present for a claimant who has right shoulder tendinitis, impairment may alternatively be assessed using section 15.7.[24] Although Dr. Blecha considered the ROM of appellant's right shoulder in evaluating permanent impairment of her right upper extremity, there is no indication that he had ROM data available to him which was obtained in accordance with the above-noted standards.[25]

In order to conduct a full evaluation of appellant's right upper extremity permanent impairment, the Board finds that the case shall be remanded to OWCP in order for it to attempt to obtain the raw data from Dr. Blecha for ROM testing of appellant's right shoulder. If the data is obtained for three measurements of each relevant type of ROM (with all measurements falling within 10 degrees of the mean of the measurements), it should be evaluated and considered under the relevant standards of the A.M.A., *Guides* as a possible basis for an impairment rating. If such data is not available, OWCP should take appropriate steps to obtain it. After developing the evidence in accordance with the Board's decision, OWCP shall issue a *de novo* decision regarding appellant's right upper extremity permanent impairment.

LEGAL PRECEDENT -- ISSUE 2

Pursuant to section 8128(a) of FECA, OWCP has the discretion to reopen a case for further merit review.[26] This discretionary authority, however, is subject to certain restrictions. For instance, a request for reconsideration must be received within one year of the date of OWCP's decision for which review is sought.[27] Timeliness is determined by the document receipt date of the request for reconsideration as indicated by the received date in the integrated Federal

[22] *See supra* notes 15 and 16.

[23] *See supra* note 14.

[24] A.M.A., *Guides* 402, Table 15-5.

[25] Dr. Blecha only provided one measurement for each type of ROM of the right shoulder.

[26] 5 U.S.C. § 8128(a); *L.W.*, Docket No. 18-1475 (issued February 7, 2019); *Y.S.*, Docket No. 08-0440 (issued March 16, 2009).

[27] 20 C.F.R. § 10.607(a).

Employees' Compensation System (iFECS).[28] Imposition of this one-year filing limitation does not constitute an abuse of discretion.[29]

OWCP may not deny a reconsideration request solely because it was untimely filed. When a claimant's request for reconsideration is untimely filed, it must nevertheless undertake a limited review to determine whether it demonstrates clear evidence of error.[30] If an application demonstrates clear evidence of error, OWCP will reopen the case for merit review.[31]

To demonstrate clear evidence of error, a claimant must submit evidence relevant to the issue which was decided by OWCP. The evidence must be positive, precise, and explicit and must manifest on its face that OWCP committed an error. Evidence that does not raise a substantial question concerning the correctness of OWCP's decision is insufficient to demonstrate clear evidence of error. It is not enough to merely demonstrate that the evidence could be construed so as to produce a contrary conclusion. This entails a limited review by OWCP of how the evidence submitted with the reconsideration request bears on the evidence previously of record and whether the new evidence demonstrates clear error on the part of OWCP. To demonstrate clear evidence of error, the evidence submitted must be of sufficient probative value to shift the weight of the evidence in favor of the claimant and raise a substantial question as to the correctness of OWCP's decision.[32]

OWCP's procedures note that the term clear evidence of error is intended to represent a difficult standard. The claimant must present evidence which on its face demonstrates that OWCP made an error (for example, proof that a schedule award was miscalculated). Evidence such as a detailed, well-rationalized medical report which, if submitted before the denial was issued, would have created a conflict in medical opinion requiring further development, is not clear evidence of error.[33] The Board makes an independent determination of whether a claimant has demonstrated clear evidence of error on the part of OWCP.[34]

[28] *Supra* note 10 at Chapter 2.1602.4(b) (February 2016).

[29] *G.G.*, Docket No. 18-1072 (issued January 7, 2019); *E.R.*, Docket No. 09-0599 (issued June 3, 2009); *Leon D. Faidley, Jr.*, 41 ECAB 104 (1989).

[30] *See* 20 C.F.R. § 10.607(b); *M.H.*, Docket No. 18-0623 (issued October 4 2018); *Charles J. Prudencio*, 41 ECAB 499, 501-02 (1990).

[31] *L.C.*, Docket No. 18-1407 (issued February 14, 2019); *M.L.*, Docket No. 09-0956 (issued April 15, 2010). *See also* 20 C.F.R. § 10.607(b); *supra* note 10 at Chapter 2.1602.5 (February 2016).

[32] *S.W.*, Docket No. 18-0126 (issued May 14, 2019); *Robert G. Burns*, 57 ECAB 657 (2006).

[33] *J.S.*, Docket No. 16-1240 (issued December 1, 2016); *supra* note 10 at Chapter 2.1602.5(a) (February 2016).

[34] *D.S.*, Docket No. 17-0407 (issued May 24, 2017).

ANALYSIS -- ISSUE 2

The Board finds that OWCP properly denied appellant's request for reconsideration as it was untimely filed and failed to demonstrate clear evidence of error.

The Board finds that OWCP properly determined that appellant failed to file a timely request for reconsideration. An application for reconsideration must be received within one year of the date of OWCP's decision for which review is sought.[35] As appellant's request for reconsideration was not received by OWCP until August 8, 2018, more than one year after issuance of its August 3, 2017 merit decision, it was untimely filed. Consequently, she must demonstrate clear evidence of error by OWCP in its August 3, 2017 decision.[36]

The Board further finds that appellant failed to demonstrate clear evidence of error on the part of OWCP in issuing its August 3, 2017 decision. Appellant failed to submit the type of positive, precise, and explicit evidence which manifests on its face that OWCP committed error in its August 3, 2017 decision.[37] The Board notes that OWCP denied appellant's claim on a medical basis, *i.e.*, the failure to submit medical evidence sufficient to expand the accepted conditions to include cervical and right knee conditions.

Appellant submitted a June 25, 2018 letter from Dr. Tacoronti who advised that an unspecified attending physician had diagnosed appellant with a right knee sprain/strain in mid-2013. In a May 22, 2017 note, Dr. Branch recommended physical therapy for appellant's right shoulder condition. Appellant also submitted a hospital discharge record from August 2017, prescription refill orders from 2017 and 2018, and lumbar spine diagnostic testing results from June 2018. The Board finds, however, that this evidence does not raise a substantial question as to the correctness of OWCP's August 3, 2017 decision.[38] Dr. Tacoronti did not identify the physician who diagnosed a right knee sprain/strain or provide any indication that this condition was related to appellant's June 5, 2013 fall at work. The other evidence appellant submitted is insufficient to show error in OWCP's August 3, 2017 decision.

As noted, clear evidence of error is intended to represent a difficult standard.[39] Even a detailed, well-rationalized medical report which, if submitted before the denial was issued, would have created a conflict in medical evidence requiring further development is insufficient to demonstrate clear evidence of error. It is not enough to show that evidence could be construed so as to produce a contrary conclusion. Instead, the evidence must shift the weight in appellant's favor.[40]

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[35] *See supra* note 24.

[36] *See supra* notes 27 and 28.

[37] *See supra* note 29.

[38] *See supra* note 29.

[39] *See supra* note 30.

[40] *M.E.*, Docket No. 18-1442 (issued April 22, 2019).

The Board finds that appellant's request for reconsideration does not demonstrate on its face that OWCP committed error when it found in its August 3, 2017 decision that appellant failed to submit medical evidence sufficient to require expansion of the accepted conditions.[41] Therefore, OWCP properly determined that appellant failed to demonstrate clear evidence of error.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish more than two percent permanent impairment of her right lower extremity, for which she previously received schedule award compensation. The case is not in posture for decision with respect to whether appellant has established greater than 13 percent permanent impairment of her right upper extremity. The Board further finds that OWCP properly denied appellant's request for reconsideration as it was untimely filed and failed to demonstrate clear evidence of error.

ORDER

IT IS HEREBY ORDERED THAT the August 28, 2018 decision of the Office of Workers' Compensation Programs is affirmed and the May 18, 2018 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded for further action consistent with this decision of the Board.

Issued: July 23, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

[41] *See S.F.*, Docket No. 09-0270 (issued August 26, 2009).